

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155402	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/15/2011
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NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 SOLDIERS HOME RD WEST LAFAYETTE, IN47906
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 12/15/11</p> <p>Facility Number: 000271 Provider Number: 155402 AIM Number: 100291260</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Heritage Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2 for the original building and a wing addition completed prior to March 1, 2003.</p> <p>This one story facility is of Type II</p>	K0000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Heritage Healthcare desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 1/14/2012.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0018 SS=E	<p>(000) construction and is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 127 and had a census of 81 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/22/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>Based on on observation and</p>	K0018	K018	01/14/2012	

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	<p>interview, the facility failed to ensure doors protecting corridor openings in 2 of 9 smoke compartments would close and latch into the door frame. This deficient practice affects staff, visitors and 56 residents on Stuart and Ross Halls.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/15/11 between 12:40 p.m. and 4:00 p.m., double doors separated linen storage closets from the corridor on the Stuart and Ross Hall. The inactive leaf in each of the door sets was held in place by a roller latch located at the top of the door, otherwise, a barrel bolt had to be manually slid into the door frame to hold the door securely closed. The inactive leave on both doors failed to hold the doors closed when tested with the maintenance director at the times of observation. The maintenance director said at the time of observations, he knew the doors needed new latching mechanisms.</p>		<p>It is the policy of this facility to ensure doors are provided with means suitable for keeping the doors closed and latched into their door frame.</p> <p>Doors to the linen closets on both Stuart and Ross halls will be replaced with doors that can support hardware that will latch the doors top and bottom into their door frame.</p>		

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K0021 SS=E	<p>3.1-19(b)</p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure smoke barrier doors or hazardous area doors in 2 of 9 smoke compartments were held open only by a device which closed the door to close automatically upon activation of the fire alarm system. This deficient practice affects visitors, staff and 48 or more residents in the dining room and Ross Hall and service corridor smoke compartments.</p> <p>Findings include:</p>	K0021	<p>K021</p> <p>It is the policy of this facility that any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, of hazardous area enclosure is held open only by devices arranged to automatically close all such doors upon activation of the fire alarm system, smoke detectors, or sprinkler system.</p> <p>1.A new smoke barrier door will be installed as part of renovations to Ross Hall.</p> <p>2.Wedges have been removed from the laundry room area. Facility will complete retraining for laundry and housekeeping staff by 1/14/2012 that the door to the laundry room must remain closed.</p> <p>3.Closers will be installed on the</p>	01/14/2012	

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	<p>a. Based on observation with the maintenance director on 12/15/11 at 4:45 p.m., one door in the Ross hall smoke barrier door set failed to close when the fire alarm was activated. The maintenance director said at the time of observation, the door had been identified as defective and a new one was to be installed as part of an ongoing renovation.</p> <p>b. Based on observation with the maintenance director on 12/15/11 at 1:30 p.m. and again at 3:05 p.m., the door providing access to the laundry near maintenance, a room larger than 50 square feet in size, was prevented from closing by a rubber wedge. The maintenance director acknowledged at the time of the observations, the wedge should not have been used.</p> <p>c. Based on observation with the maintenance director on 12/15/11 at 1:40 p.m., the double door kitchen access door set was prevented from self closing. The doors in the double door set were held open by folded paper towels and a rubber wedge under the open doors. The maintenance director acknowledged at the time</p>		<p>kitchen access double doors that will automatically close all such doors upon activation of the fire alarm system, smoke detectors, or sprinkler system.</p> <p>4. Closer will be installed on the kitchen dish room door that will automatically close all such doors upon activation of the fire alarm system, smoke detectors, or sprinkler system.</p>		

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K0029 SS=E	<p>of the observations, the items should not have been used.</p> <p>d. Based on observation with the maintenance director on 12/15/11 at 1:50 p.m., the self closing access door to the kitchen dish room was equipped with a self closing device which held the door open when pushed open wide. The maintenance director confirmed at the time of observation, the door would not self close upon activation of the fire alarm.</p> <p>3.1-19(b)</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to provide a functioning automatic closer for the door providing</p>	K0029	<p>K029</p> <p>It is the policy of this facility that doors protecting hazardous areas are self closing.</p> <p>1.</p> <p>1.New door self closure was</p>	01/14/2012	

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	<p>access to 2 of 8 hazardous areas such as a combustibile materials storage room larger than 50 square feet or soiled linen storage area. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically or upon activation of the fire alarm system. This deficient practice could affect visitors, 6 staff and residents in the service corridor.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 12/15/11 at 2:50 p.m., the door separating the nine by sixteen foot laundry storage room near maintenance from the exit corridor had no self closing device. The room was equipped with shelves laden with combustibile linens and plastic wrapped items. The maintenance director said at the time of observation, he didn't realize the door was required to self close.</p> <p>b. Based on observation with the maintenance director on 12/15/11 at 3:45 p.m., the spring functioning to self close the access door to the Stuart Hall</p>		<p>installed on the door separating the laundry storage room from the exit corridor.</p> <p>2.New door self closure was installed on the Stuart Hall shower room door.</p> <p>2. The receptacles used for isolation procedures were removed from room 27 and 28. Training will be provided to housekeeping and nursing administration about the appropriate size receptacles that can be used in a room without a self closing door.</p> <p>3. The vents that were located in the wall separating the mechanical room and charting room on Duncan Hall have been removed and the wall closed.</p>		

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	<p>shower room failed to close the door leaving a half inch gap between the door and door frame. The room was used for the collection of soiled linens in five barrels with a capacity greater than 32 gallons. Each was half or more full. The maintenance director said at the time of observation, the spring had sprung and lost its' capacity to close the door.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure unattended soiled linen and trash receptacles with a total capacity exceeding 32 gallons capacity within any 64 square foot area were stored in a room protected as a hazardous area in 1 of 9 smoke compartments. This deficient practice affects visitors, staff and 23 residents on the Earhart Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/15/11 between 3:40 p.m. and 4:00 p.m.,</p>				

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	<p>two soiled linen and trash receptacles standing side by side were observed through the open resident room doors of room 27 and 28 on Earhart Hall. The receptacles were half or more full and had the capacity for 28 to 32 gallons. The doors had no self closing devices. The maintenance director said at the time of observation, the receptacles were for special isolation trash and soiled linen collection.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to provide a smoke resistant partition and self closing door for 1 of 3 sprinklered mechanical rooms. This deficient practice affects visitors, staff and 32 residents on Duncan Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/15/11 at 4:20 p.m., the Duncan Hall exit corridor was exposed to a mechanical room housing a gas fired water heater. The water</p>				

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K0038 SS=D	<p>heater was located in a mechanical room behind the charting room on the Duncan Hall. Two vents were located in the wall separating the mechanical room from the charting room. The self closing door to the charting room was held wide open by a chart rack, and as a consequence, the mechanical room was also open to the exit corridor. The maintenance director said at the time of observation, he did not know why the vents were located in the the wall at all.</p> <p>3.1-19(b)</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 laundry room exit doors were provided with door knobs readily operated under all lighting conditions. LSC 7.2.1.5.4. requires where a latch or other similar device is provided,</p>	K0038	<p>K038</p> <p>It is the policy of this facility to ensure that exit access is arranged so that exits are readily accessible at all times. The second lock to the laundry exit door to the Duncan Hall corridor was removed. Door and door jamb were repaired.</p>	01/14/2012

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	<p>the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one which is familiar to the average person. For example, a two step release, such as a knob and independent dead bolt, is not acceptable. In most occupancies, it is important that a single action unlatch the door. This deficient practice could affect 1 staff observed in the laundry.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/15/11 at 3:10 p.m., the laundry exit door providing access to the Duncan hall corridor and central lobby was marked with an exit sign above the door. The door was equipped with a dead bolt latch and lockable door knob. In order to open the door from the interior, it was necessary to turn the dead bolt and door knob at the same time. The maintenance director agreed at the time of observation, the door took more than a single action to open with this equipment.</p>				

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K0048 SS=C	<p>3.1-19(b)</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview the facility failed to ensure the facility fire plan provided effective staff training for the protection of 81 of 81 residents. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p>	K0048	<p>K048</p> <p>It is the policy of this facility that there is a written plan for the protection of all patients and for their evacuation in the event of an emergency.</p> <p>The facility Fire Procedures were updated to read: "If you feel you are able to, extinguish the fire by some means, including the use of fire extinguishers." A paragraph was also added explaining the use of the K class fire extinguisher.</p>	01/14/2012

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	<p>Based on review of the facility Fire Procedures with the maintenance director on 12/15/11 at 1:55 p.m., the document implemented a RACE procedure with direction after each letter listed including: "E- Evacuate as directed by the person in charge." A note added the direction: "If the fire is small" to extinguish it by some means including the use of fire extinguishers. There was no information in the fire plan for the two different fire extinguishers located in the facility. The maintenance director said at the time of record review, training was conducted annually for fire extinguisher use but no specific staff training was given for the K Class extinguisher located in the kitchen and determining the size of a fire.</p> <p>3.1-19(b)</p>				

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K0056 SS=E	<p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed install sprinkler heads in the physical therapy room so they were separated by at least the minimum distance between sprinklers in 1 of 9 smoke compartments. NFPA 13, 1999 Edition at 5-7.3.4 requires sprinklers shall be spaced not less than 6 feet on center. This deficient practice affects staff, visitors and 32 residents on the Duncan Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/15/11 at 4:40 p.m., three pendant ceiling sprinkler heads were measured 24 inches, 53 inches and 54 inches apart in the Duncan Hall physical</p>	K0056	<p>K056</p> <p>It is the policy of this facility to maintain an automatic sprinkler system to provide complete coverage for all portions of the building. The three sprinkler heads in the physical therapy room that are too close to each other will be removed and repositioned appropriately.</p>	01/14/2012			

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K0062 SS=E	<p>therapy room. The maintenance director said at the time of observation, walls had been removed and the sprinkler head locations had not been reassessed.</p> <p>3.1-19(b)</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 kitchen cooler and freezer sprinkler heads were free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further, NFPA 13, Standard for the Installation of Sprinkler Systems, in 5-5.6 requires the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice affects 4 occupants in the kitchen.</p> <p>Findings include:</p>	K0062	<p>K062</p> <p>It is the policy of this facility that automatic sprinkler systems are continuously maintained in a reliable operating condition. The items in the food storage area that was obstructing the sprinkler spray were moved. A line was painted on the wall clearly indicating the area above which items could not be stored.</p>	01/14/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155402	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 12/15/2011
NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3401 SOLDIERS HOME RD WEST LAFAYETTE, IN47906		
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K0147 SS=E	<p>Based on observation with the maintenance director on 12/15/11 at 3:15 p.m., food storage was located six inches or less from the sprinkler heads located in the commercial kitchen cooler and freezer. The maintenance director acknowledged at the time of observation, the stored items could obstruct the sprinkler spray if activated.</p> <p>3.1-19(b)</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 5 of 5 flexible cords or multitap adapters were not used as a substitute for fixed wiring. NFPA 70 (National Electrical Code), 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 60</p>	K0147	<p>K147</p> <p>It is the policy of this facility that electrical wiring and equipment is in accordance with the National Electric Code.</p> <p>The multitap outlet adapters have been removed from the Duncan hall kitchenette, and rooms 24.</p> <p>The multi plug adapters were removed in rooms 56, 57, & 58.</p> <p>Date of Compliance: 1/14/2012</p>	01/14/2012	

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	<p>residents on Duncan and Ross halls.</p> <p>Findings include:</p> <p>Based on observations with the maintenance director on 12/15/11 between 1:30 p.m. and 5:00 p.m., multitap outlet adapters were used to provide power to equipment in the Duncan Hall kitchenette and resident rooms 56, 57 and 58 on Duncan Hall. On 12/15/11 at 3:15 p.m., a power strip was observed in resident room 24 on Ross Hall used to power a feeding tube pump. The maintenance director said at the time of observations, he didn't know the multitap electrical equipment should not have been in use.</p> <p>3.1-19(b)</p>				